LESSON 4

INTRODUCTION TO CAFETERIA PLANS

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Cafeteria Plans

Section 125 of the Internal Revenue Code makes it possible for employers to offer their employees a choice between cash and a variety of nontaxable benefits without the application of the constructive receipt rules with respect to income

recognition by the employees.

See, §125(a), §1.125-1, Q&A-1, §1.125-2, Q&A-2.

Section 125 was enacted in 1978 and amended in 1980, 1984, 1986, 1988 and 1996. Proposed regulations were issued on May 7, 1984 and were amended on December 31, 1984. Additional regulations were proposed on March 7, 1989 and December 21, 1995. These proposed regulations have not been finalized. Most recently, a set of temporary regulations were published on November 7, 1998.

Plan Requirements

A cafeteria plan is a written benefit plan maintained by an employer for the benefit of its employees. The plan must allow employees to choose between two or more benefits consisting of cash (or a taxable benefit which is treated as cash) and certain "qualified benefits."

See, §125(d), §1.125-1, Q&A-2, §1.125-2, Q&A-3.

The written plan must include the following provisions:

1. A specific description of each benefit available under the plan and the period of coverage.

2. The rules governing which employees are eligible to participate in the plan.

3. The procedures for making elections under the plan, including when elections may be made, the rules governing irrevocability of elections and the periods for which elections are effective.

4. The manner in which employer contributions may be made such as by salary reduction agreement between the employer and employee, by nonelective employer contributions or by both.

5. The maximum amount of employer contributions available to any participant. To meet this requirement, the plan must describe the maximum amount of elective contributions available to any employee either by stating the maximum dollar amount or maximum percentage of compensation that may be contributed as elective contributions or by stating the method for

determining the maximum amount or percentage of elective contributions that an employee may make.

6. The plan year.

See, §1.125-1, Q&A-3, §1.125-2, Q&A-3.

Employee

The term "employee" includes both present and former employees, but not self-employed individuals described in section 401(c). Thus, sole proprietors, partners in a partnership and 2% or greater shareholders in an S-corporation are ineligible to participate in a cafeteria plan. In addition, the plan may not be established primarily for the benefit of former employees.

A spouse or other beneficiary of a plan participant may receive benefits under a cafeteria plan; however, only the plan participant may make the election of benefits under the plan.

See, §125(d)(1)(A), §1.125-1, Q&A-4.

Deferred Compensation

A cafeteria plan may not offer any benefit which defers the receipt of compensation (other than a section 401(k) plan). Therefore, the plan may not permit participants to use one plan year's contributions to purchase benefits in a subsequent plan year, or to carryover unused benefits from year to year.

See, §125(d)(2), §1.125-1, Q&A-7, §1.125-2, Q&A-5.

Qualified Benefits

A qualified benefit is a benefit that does not defer compensation and which is excludable from an employee's gross income under a specific provision of the Code. Qualified benefits include the following:

a. Employer-provided accident or health coverage under sections 105 and 106. This includes health, medical, hospitalization coverage, disability insurance and coverage under an accidental death and dismemberment policy. It also includes reimbursement for health care expenses under a

health flexible spending arrangement (FSA). Individually owned accident or health insurance policies may be offered under a cafeteria plan provided that the employer requires an accounting to insure that the health insurance is in force and is being paid by the employees. See, Rev. Rul. 61-146, 1961-2 C.B. 25. Moreover, the plan may not reimburse the health insurance premiums under a health FSA.

b. Employer-provided group-term life insurance coverage which is either excludable from income under section 79 or includible in income solely because the benefit exceeds the dollar limit of section 79 ($50,000). Dependent group term life insurance may not be included in a cafeteria plan if the benefit is eligible for exclusion under section 132. See, Notice 89-110, 1989-2 C.B. 447.

c. Employer-provided qualified group legal services under section 120. Note: This statute expired on June 30, 1992.

d. Employer-provided dependent care assistance under section 129.

e. Employer-provided adoption assistance under section 137.

f. A 401(k) plan or purchase of retiree group term life insurance by participants employed by certain educational institutions described in section 170(b)(l)(A)(ii).

The following benefits are not qualified benefits under a cafeteria plan:

a. Contributions to medical savings accounts under section 106(b);

b. Qualified scholarships under section 117;

c. Educational assistance programs under section 127;

d. Certain fringe benefits under section 132; and

e. Qualified long-term care insurance under section 7702B.

See, §125(f), §1.125-1, Q&A-5, §1.125-2, Q&A-4.

Cash Requirement

A cafeteria plan must offer a cash option. Cash benefits include not only cash, but also benefits which may be purchased with after-tax dollars, or the value of which is generally treated as taxable compensation to the employee.

See, §125(d)(1)(B), §1.125-1, Q&A-5, §1.125-2, Q&A-(b) and (c), and Q&A-5(c).

Qualified scholarships under section 117, and employerprovided fringe benefits under section 132 may not be included in a cafeteria plan even if purchased with after-tax contributions.

See, §1.125-2, Q&A-4(d).

Salary Reduction

Employer contributions to the cafeteria plan are usuallymade pursuant to salary reduction agreements between the employer and the employee in which the employee agrees to contribute a portion of his or her salary on a pre-tax basis to pay for the qualified benefits. Salary reduction contributions are not actually or constructively received by the participant. Therefore, those contributions are not considered wages forfederal income tax purposes. In addition, those sums generally are not subject to FICA and FUTA. A salary reduction agreement is sufficient to satisfy the "cash" requirement of a cafeteria plan. Thus, a cafeteria plan need only offer a choice between one qualified benefit and salary reduction.

See, §§3121(a)(5)(G) and 3306(b)(5)(G), §1.125-1, Q&A-6, 14 and 16.

Election Requirements

For participants to avoid constructive receipt of taxable benefits, the plan must offer an election, and participants must elect the amounts and types of benefits to be received prior to the beginning of the plan year. If salary reduction is permitted to pay for the benefits chosen, the salary reduction amount must be elected prior to the beginning of the coverage period.

Generally, the plan may not permit participants to elect their benefit coverage, benefit reimbursement, or salary reduction for less than 12 months. However, this does not prohibit new employees from electing benefits for a part of the cafeteria

plan year.

See, §125(d)(2), §1.125-1, Q&A-6, 8, and 15, §1.125-2, Q&A-6.

Revocation of Elections

After a participant has elected and begun to receive benefits under the plan, the plan may not allow the participant to revoke the benefit election during the period of coverage unless the revocation is due to one of the following events:

a. Health Insurance Portability and Accountability Act of 1996 (HIPAA) special enrollment rights.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires group health plans to permit individuals to be enrolled for coverage following the loss of other health coverage, or if a person becomes the spouse or dependent of an employee through birth, marriage, adoption or placement for adoption. If a participant has a right to enroll in an employer's group health plan or to add coverage for a family member under HIPAA, the participant can revoke an existing election and make a new election under the cafeteria plan that conforms with the special enrollment right.

See, §1.125-4T(b), §9801 (f), §54.9801-6T.

b. Changes in status.

Under the change in status rules, a plan may permit participants to revoke an election and make a new election with respect to accident and health coverage and group-term life insurance, if,

(1) a change in status occurs and

(2) the election change is "consistent" with the change in status.

Change in status events are changes in legal marital status, number of dependents, employment status, work schedule, and residence or worksite, and cases where the dependent satisfies or ceases to satisfy the requirements for unmarried dependents. An election change is "consistent" if the change in status event affects eligibility for coverage and the change in election corresponds with the affect on eligibility. Election changes must be on a prospective basis.

See, §1.125-4T(c).

c. Judgment, decree or order.

A plan may permit a participant to revoke and change an election if a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody requires accident and health coverage for a participant's child.

See, §1.125-4T(d).

d. Entitlement to Medicare or Medicaid.

A plan may permit a participant to revoke an election for accident or health coverage if the participant, spouse or dependent becomes entitled to Medicare or Medicaid.

See, §1.125-4T(e).

e. Changes in contributions to 401(k) plans.

A plan may permit an employee to modify or revoke elections in accordance with sections 401(k) and 401(m) and the regulations thereunder.

See, §1.125-4T(j).

f. Changes in family status.

For benefits other than accident and health coverage and group-term life, changes in family status include the marriage or divorce of the participant, the birth or

adoption of a child of the participant, the termination of employment (or commencement of employment) of the participant's spouse, the switching from part-time to full-time employment or vise versa by the participant or the participant's spouse, the taking of an unpaid leave of absence by the participant or the participant's spouse, and significant changes in the health coverage of the participant or participant's spouse attributable to the spouse's employment (e.g., spouse's employer terminates its health plan). This list is not all inclusive and there may be other similar events that would be considered a change in family status. Election changes due to family status changes must be "consistent" with the family status change and generally must be made on a prospective basis.

See, §1.125-1, Q&A-8 and §1.125-2, Q&A-6.

g. Significant cost or coverage changes.

If the cost under a health plan provided by an independent, third party provider increases or decreases during the plan year, the plan may automatically increase or decrease all affected participant contributions for such health plan. In the alternative, if the premium amount significantly increases, the plan may permit participants to either make a corresponding change in their premium payments or revoke their elections and, in lieu thereof, to receive coverage under another health plan with similar coverage. In this case, no additional adjustments or revocations may be made under the plan (e.g., health flexible spending arrangement). If the coverage provided by an independent, third party provider ceases or is significantly curtailed, the plan may permit participants to revoke their elections of the health plan and, in lieu thereof, to receive prospective coverage under another health plan with similar coverage.

See, §1.125-1, Q&A-8 and §1.125-2, Q&A-6

h. Family and Medical Leave Act (FMLA).

A plan must allow a participant who takes unpaid FMLA leave to revoke an existing election for health plan coverage for the remainder of the coverage period (notwithstanding any contrary rules stated in the cafeteria plan document). A participant who takes FMLA leave may revoke elections for non-health benefits only under the same rules that apply to participants taking non-FMLA leave. In either case, the participant may choose to be reinstated in the plan upon return from FMLA leave on the same terms and conditions as prior to taking FMLA leave.

See, §1.125-3, Q&A-1 and Q&A-7.

Flexible Spending Arrangements

An FSA is an arrangement that provides coverage under which specified, incurred expenses may be reimbursed and the maximum amount of reimbursement reasonably available to a participant for a period of coverage is not substantially in excess of the total premium for such coverage (i.e., the maximum amount of reimbursement is less than 500% of the premium). Like all qualified benefits, FSA coverage must meet all of the rules under the relevant Code section (e.g., sections 105, 106 and 129) in order to be excludable from gross income.

See, §1.125-1, Q&A-16, §1.125-2, Q&A-7(c)

a. Health FSAs.

A health FSA must qualify as an accident or health plan (i.e., it must exhibit the risk-shifting and riskdistribution characteristics of insurance). Thus, a health FSA must provide "uniform coverage" throughout the coverage period. This means that the maximum amount of reimbursement (i.e., the annual election) must be available to the participant at all times. For example, if an employee elects salary reduction of $100 per month for a health FSA, the employee's annual election of $1200 must be available to the employee for reimbursement at any time during the plan year (properly reduced for prior reimbursements) without regard to the employee's actual contributions to the plan at that time. In addition, the plan may not accelerate the payment schedule based upon the claims that the employee has made. Reimbursements under a health FSA must be paid specifically to reimburse the participant for medical expenses. A reimbursement is not paid specifically to reimburse the participant for medical expenses if the participant is entitled to these amounts in the form of cash or any taxable benefit, without regard to whether the participant incurs medical expenses during the period of coverage. Reimbursements are permissible for medical expenses as defined in section 213 of the Code with the exception of premiums for other health plan coverage (e.g., major medical policies).

A health FSA cannot operate in a manner that enables participants to

receive coverage only for periods during which they expect to incur medical expenses. Consequently, the period of coverage under a health FSA generally must be 12 months or the entire length of a short plan year.

The participant must substantiate all claims for reimbursement under a health FSA. Thus, the participant must provide both a written statement that the expense has not been reimbursed (or is not reimbursable) under any other health plan coverage and a written statement from an independent, third party provider verifying the date and the amount incurred.

Reimbursements may only be made for claims incurred during the period of coverage. Expenses are treated as having been incurred when the participant is provided with the medical care that precipitates the expense, not when the participant is billed or pays for the care.

Amounts unused by the participant at the end of the plan year are forfeited. If this was not the case, the FSAs would be a mechanism for deferring compensation.

See, §1.125-1, Q&A-17, §1.125-2, Q&A-7 (a) and (b)(1) through (7).

b. Dependent Care Assistance FSAs.

The same rules that apply to health FSAs also apply to dependent care FSAs except that coverage does not have to be uniform during the coverage period. Thus, a participant is only entitled to reimbursement of amounts actually contributed to the plan.

See, §1.125-1, Q&A-18, §1.125-2, Q&A-7(b)(8).

Reporting and Filing Requirements

All employers that maintain cafeteria plans are required to file an information return (Form 5500 series with Schedule F) for each year. There are no exceptions to this requirement.

The returns are due on or before the last day of the seventh month after the end of the plan year. The plan sponsor (i.e., employer) is responsible for filing the return. Plan sponsors who fail to file the return are subject to a penalty of $25 per day. The maximum penalty will not exceed $15,000 and is subject to the reasonable cause provisions.

See, §§125(h), 6039D, 6652(e).

Cafeteria Plan Examinations

Appendices A through C contain various documents useful in cafeteria plan examinations.